Exhibit A4

N6-02768*01*004970-EO-09174-80740-AFN 11900
CFEB02-980817

UNITEDHEALTHCARE INSURANCE COMPANY
KINGSTON SERVICE CENTER
P.O. BOX 30985
SALT LAKE CITY, UT 84130
PHONE: 1-800-842-9905
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 06/23/09
SSN/ID #:
EMPLOYEE:
CONTRACT: 0023000
BENEFIT PLAN: RAILROAD EMPLOYEES

EXPLANATION OF BENEFITS

SERVICE DETAIL

1108761001	PARAGON OFFICE ANESTHESIA	10/27/08	6550.00	6550.00	0.00*	8Z
		TOTAL	6550.00	6550.00	0.00	

PLAN PAYS	0.00
** PATIENT PAYS	6550.00

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

** DEFINITION: "PATIENT PAYS" IS THE AMOUNT, IF ANY, OWED YOUR PROVIDER. THIS MAY INCLUDE AMOUNTS ALREADY PAID TO YOUR PROVIDER AT TIME OF SERVICE.

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(8Z) YOUR PLAN DOES NOT COVER THIS FAMILY PLANNING SERVICE OR ASSOCIATED EXPENSE.

FAMILY		$608.20		$285.68
		$608.20		$285.68
PLAN YEAR 2008	FAMILY:	$4000.00	FAMILY:	$900.00
	INDIV:	$2000.00	INDIV:	$300.00

A REVIEW OF THIS BENEFIT DETERMINATION MAY BE REQUESTED BY SUBMITTING YOUR APPEAL TO US IN WRITING AT THE FOLLOWING ADDRESS: UNITEDHEALTHCARE APPEALS, P.O. BOX 30432, SALT LAKE CITY, UT 84130-0432. THE REQUEST FOR YOUR REVIEW MUST BE MADE WITHIN 180 DAYS FROM THE DATE YOU RECEIVE THIS STATEMENT. IF YOU REQUEST A REVIEW OF YOUR CLAIM DENIAL, WE WILL COMPLETE OUR REVIEW NOT LATER THAN 30 DAYS AFTER WE RECEIVE YOUR REQUEST FOR REVIEW.

YOU MAY HAVE THE RIGHT TO FILE A CIVIL ACTION UNDER ERISA IF ALL REQUIRED REVIEWS OF YOUR CLAIM HAVE BEEN COMPLETED.

* * * * * * *

YOU CAN MEET MANY OF YOUR NEEDS ONLINE AT WWW.MYUHC.COM. AT ALMOST ANYTIME DAY OR NIGHT, YOU CAN REVIEW CLAIMS, CHECK ELIGIBILITY, LOCATE A NETWORK PHYSICIAN, REQUEST AN ID CARD, REFILL PRESCRIPTIONS IF ELIGIBLE, AND MORE! FOR IMMEDIATE, SECURE SELF-SERVICE, VISIT WWW.MYUHC.COM.

HOW TO REGISTER?
YOU CAN REGISTER AND BEGIN USING MYUHC IN THE SAME SESSION. ACCESS WWW.MYUHC.COM TO REGISTER. THE INFORMATION REQUIRED IS ON YOUR INSURANCE ID CARD (FIRST NAME, LAST NAME, MEMBER ID, GROUP NUMBER AND DATE OF BIRTH).

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THIS IS NOT A BILL

P6-00798*01*001529-EO-09280-40044-AFN 11SN0
CFEB02-980817

UNITEDHEALTHCARE INSURANCE COMPANY
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-638-8884
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 10/07/09
SSN/ID #:
EMPLOYEE:
CONTRACT: 0201057
BENEFIT PLAN: RAYTHEON COMPANY

EXPLANATION OF BENEFITS

SERVICE DETAIL

PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
9079452701	PARAGON AMBULATORY ANESTHESIA	06/26/09	2250.00	2250.00				0.00*	Q8
		TOTAL	2250.00	2250.00				0.00	

PLAN PAYS 0.00
** PATIENT PAYS 2250.00

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

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(Q8) THIS PROCEDURE CODE AND MODIFIER ARE THE SAME AS OR EQUIVALENT TO ANOTHER PROCEDURE CODE AND MODIFIER PREVIOUSLY SUBMITTED BY ANOTHER HEALTH CARE PROVIDER. NO FURTHER BENEFITS ARE AVAILABLE FOR THIS SERVICE.

SATISFIED 2009 TO DATE	IN NETWORK DEDUCTIBLE	IN NETWORK OUT OF POCKET	OUT OF NETWORK DEDUCTIBLE	OUT OF NETWORK OUT OF POCKET
FAMILY	$104.17	$104.17	$110.00	$0.00
	$104.17	$104.17	$110.00	$0.00
PLAN YEAR 2009	FAMILY: $300.00 INDIV: $150.00	FAMILY: $3000.00 INDIV: $1500.00	FAMILY: $1200.00 INDIV: $600.00	FAMILY: $12000.00 INDIV: $6000.00

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* * * * * * *

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* * * * * * *

MAINTAINING THE PRIVACY AND SECURITY OF INDIVIDUALS' PERSONAL INFORMATION IS VERY IMPORTANT TO US AT UNITEDHEALTHCARE. TO PROTECT YOUR PRIVACY, WE HAVE IMPLEMENTED STRICT CONFIDENTIALITY PRACTICES. THESE PRACTICES INCLUDE THE ABILITY TO USE A UNIQUE INDIVIDUAL IDENTIFIER. YOU MAY SEE THE UNIQUE INDIVIDUAL IDENTIFIER ON UNITEDHEALTHCARE CORRESPONDENCE, INCLUDING MEDICAL ID CARDS (IF APPLICABLE), LETTERS, EXPLANATION OF BENEFITS (EOBS) AND PROVIDER REMITTANCE ADVICES (PRAS). IF YOU HAVE ANY QUESTIONS ABOUT THE UNIQUE INDIVIDUAL IDENTIFIER OR ITS USE, PLEASE CONTACT YOUR CUSTOMER CARE PROFESSIONAL AT THE NUMBER SHOWN AT THE TOP OF THIS STATEMENT.

THIS IS NOT A BILL

SM-02120*02*006990-EO-09224-H0261-AFN 11SYM
CFEB02-980817

UNITEDHEALTHCARE INSURANCE COMPANY
SPRINGFIELD SERVICE CENTER
P O BOX 30555
SALT LAKE CITY, UT 84130-0555
PHONE: 1-866-317-6369
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 08/12/09
SSN/ID #:
EMPLOYEE:
CONTRACT: 0704237
BENEFIT PLAN: MUHTAMAKI AMERICAS, INC.

EXPLANATION OF BENEFITS

SERVICE DETAIL

4156666801	PARAGON OFFICE ANESTHESIA	04/02/09	6550.00	6550.00	0.00*	AF
		TOTAL	6550.00	6550.00	0.00	

PLAN PAYS 0.00
** PATIENT PAYS 6550.00

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

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REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(AF) REIMBURSEMENT HAS BEEN PREVIOUSLY ISSUED FOR THESE DATES OF SERVICE.

A REVIEW OF THIS BENEFIT DETERMINATION MAY BE REQUESTED BY SUBMITTING YOUR APPEAL TO US IN WRITING AT THE FOLLOWING ADDRESS: UNITEDHEALTHCARE APPEALS, P.O. BOX 30432, SALT LAKE CITY, UT 84130-0432. THE REQUEST FOR YOUR REVIEW MUST BE MADE WITHIN 180 DAYS FROM THE DATE YOU RECEIVE THIS STATEMENT. IF YOU REQUEST A REVIEW OF YOUR CLAIM DENIAL, WE WILL COMPLETE OUR REVIEW NOT LATER THAN 30 DAYS AFTER WE RECEIVE YOUR REQUEST FOR REVIEW.

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THIS IS NOT A BILL

SM-01590*01*005344-EO-09238-H0364-ACN 11S0P
CFEB02-980817

UNITEDHEALTHCARE INSURANCE COMPANY
SPRINGFIELD SERVICE CENTER
P.O. BOX 30555
SALT LAKE CITY, UT 84130-0555
PHONE: 1-866-317-6369
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 08/26/09
SSN/ID #:
EMPLOYEE:
CONTRACT: 0187381
BENEFIT PLAN: ALCON LABS, INC.

EXPLANATION OF BENEFITS

SERVICE DETAIL

PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
6241854701	PARAGON OFFICE ANESTHESIA	05/01/09	6500.00	6500.00				0.00*	AF
		TOTAL	6500.00	6500.00				0.00	
							PLAN PAYS	0.00	
							** PATIENT PAYS	6500.00	

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SATISFIED 2009 TO-DATE	IN NETWORK OUT OF POCKET	OUT OF NETWORK DEDUCTIBLE	OUT OF NETWORK OUT OF POCKET
FAMILY	$145.00	$0.00 $0.00	$145.00
PLAN YEAR 2009	INDIV: $1500.00	FAMILY: $400.00 INDIV: $200.00	INDIV: $3500.00

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